Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TROPHY CLUB MEDICAL CENTER 2850 EAST STATE HIGHWAY 114 TROPHY CLUB TX 76262	MFDR Tracking #: M4-10-3218-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ACE INSURANCE COMPANY OF TEXAS Rep Box #: 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Rationale for Increased Reimbursement taken from the Table of Disputed Services: "Not paid at 200% APC. Appealed on 12/22/09. Lack of acknowledgement from carrier."

Principle Documentation:

1. DWC 60 package
2. Hospital Bill(s)
3. Explanation of Benefits (EOBs)
4. Medical Records
5. Total Amount Sought $2,033.98

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary dated 04/01/2010: "Carrier has resubmitted date of service 8-18-2009, to be re-audited. Carrier has not received the re-audited EOR. At this time, Carrier stands on the position of the prior audited bill. When Carrier receives the re-audited EOR and if additional allowance is due, Carrier will pay and send the corrected EOR and payment screen in a follow up Addendum statement. However, if additional allowance is not recommended, Carrier will send the EOR with the explanation of denial."

Principle Documentation:

1. Response package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
08/18/09	**Hospital Outpatient Surgical Services** CPT Code 62350 CPT Code 76000-TC	**CPT Code 62350**: $2,746.53 (APC + Outlier) x 200% = $5,493.06 (OPPS) - $3,493.00 (Paid by Respondent) = $2,000.06 (Due Requestor) **The requestor is seeking $1,977.06 for this code.** **CPT Code 76000-TC**: Not separately reimbursable.	$2,033.98	$1,977.06
			Total Due:	$1,977.06

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for medical dispute resolution under 28 TAC §133.305 (a)(4).

1. The disputed services were denied or reduced by the insurance carrier based upon:

   Explanation of benefits dated 11/18/09 noted claim reduction codes:
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 370 — THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - C26 — APPROVAL REQUIRED DUE TO CLAIM STATUS OR CLAIM INSTRUCTIONS.

2. Division rule at 28 TAC §134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."

3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

4. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:

   (1) No documentation was found to support a contractual agreement between the parties to this dispute;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

6. The requestor lists CPT code 62350 and 76000-TC as the codes in dispute.

7. CPT code 62350, is a Status T code which is defined as outpatient significant procedure subject to multiple procedure discounting. The highest paying Status T APC, CPT Code 62350, is paid at 100%; all others are paid at 50%. This amount multiplied by 200% is the MAR. This code is reimbursed according to 28 TAC §134.403(f)(1)(A) as follows: $2,746.53 x 200% = $5,493.06. The respondent paid $3,493.00, leaving a balance due requestor of $2,000.06. The requestor is seeking $1,977.06.

8. CPT code 76000 was billed with a –TC modifier. This code is a Status N which is defined as service/procedure included in the APC rate but NOT paid separately (this is a packaged item). No reimbursement is allowed for this code.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $1,977.06.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403, §133.307 and §133.305

PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $1,977.06 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

		August 30, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.